MEDI-CAL UPDATE Part 2
Billing and Policy
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Allied Health • Durable Medical Equipment and Medical Supplies

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Contents

2005 CPT-4/HCPCS Updates: Implementation November 1, 2005

The 2005 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2005. Specific policy changes are highlighted below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

DURABLE MEDICAL EQUIPMENT

Deleted and Replacement HCPCS Codes

The following are deleted HCPCS DME codes and their 2005 replacement codes. The policy of the deleted code(s) applies to the replacement code(s).

Deleted Code(s)	Replacement Code(s)
K0627	E0849
K0059 – K0061	E2205
K0081	E2206
E1012	E2292
E1013	E2294
K0650 – K0666	E2601 – E2617, respectively
K0668	E2619

Billing and Reimbursement Restrictions for Select DME HCPCS Codes

New HCPCS code A7045 (exhalation port for positive airway device) is a supply for another DME item and may only be purchased as a replacement for patient-owned equipment. Code A7045 requires a *Treatment Authorization Request* (TAR) and must be billed with modifier -NU (new equipment [purchase]). Reimbursement is limited to one in a 12-month period.

Code E0637 (patient lift, combination sit to stand system, any size, with seat lift, with or without wheels) must now be billed "By Report."

Code E0849 (traction equipment, cervical, free-standing stand/frame) requires prior authorization and is taxable.

Codes E8000 – E8002 (gait trainers) require prior authorization and are reimbursable only for recipients 65 years of age and younger.

Billing and Reimbursement Restrictions for Select Wheelchair and Wheelchair Accessories Codes

Codes E1229, E1239, E2291 – E2294, E2609 – E2610 and E2617 – E2618 require prior authorization.

Codes E2205 and E2206 are not separately reimbursable with codes E1161, E1229, E1231 – E1238, K0001 – K0007 and K0009 when billed during the same month of service.

Code E2368 is not separately reimbursable with codes E1239, K0010 – K0012 and K0014 when billed for the same month of service.

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

Purchase Frequency Restrictions for Select DME Codes
The following DME HCPCS codes have purchase restrictions as noted:

- Codes E2291 – E2294 and E2601 – E2621 are limited to one in a 12-month period.
- Codes E2205 and E2206 are limited to two in a 12-month period.
- Codes E0849, E1039, E1229, E1239, E2368 – E2370 and E8000 – E8002 are limited to one in three years.

Benefits for CCS Clients
The following new DME HCPCS codes are benefits for California Children's Services (CCS) clients only:

- E0463 and E0464 (ventilator)
- E0639 (movable patient lift)
- E0640 (fixed patient lift)

These codes may be reimbursed for Medi-Cal recipients (21 years of age or older) only with an approved TAR.

Reimbursement Restrictions
Ventilator codes E0463 and E0464 may only be rented (bill with modifier -RR [rental]).

Patient lift codes E0639 and E0640 are taxable. Purchase reimbursement is limited to one in three years.

Special Power Wheelchair Interfaces
New DME modifier -KC (replacement of special power wheelchair interface) is activated for use with HCPCS codes E2320 – E2322 and E2327 (special interface for power wheelchair). Claims for these codes must now be billed "By Report" with modifier -NU or -RR at the time the wheelchair is initially purchased or rented. Reimbursement will be the lesser of the amount billed or the maximum allowable for modifier -NU or -RR, as appropriate. Subsequent claims for the replacement of these special interfaces must be billed with modifiers -RP/-NU/-KC or -RR/-KC in that specific order. Reimbursement will be the lesser of the amount billed or the maximum allowable for modifier -KC. Following are the modifier-specific reimbursement rates for these codes:

HCPCS Code	Rental Rates		Purchase Rates	
	-RR	-RR/-KC	-NU	-RP/-NU/-KC
E2320	$102.59	$139.07	$1,025.90	$1,390.58
E2321	$158.92	$223.10	$1,589.10	$2,231.00
E2322	$141.03	$236.26	$1,410.36	$2,362.59
E2327	$261.24	$342.08	$2,612.38	$3,420.77

Reimbursement Adjustments for Select DME Codes
Due to recent adjustments to the Medicare rates for HCPCS codes E0260, E0277, E0431, E0434, E0439, E0570, E1010, E1390, E1391, E2320 – E2324, E2326 – E2330, E2340, E2341 – E2343 and K0001, the Medi-Cal reimbursement rates for these codes have been revised.

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

ORTHOTICS AND PROSTHETICS

Deleted and Replacement HCPCS Codes

The following are deleted HCPCS prosthetics codes and their 2005 replacement codes. The policy of the deleted code applies to the replacement code.

Deleted Codes	Replacement Code
L5674, L5675	L5685

Reimbursement Restrictions for New Orthotic and Prosthetic Codes

The following new HCPCS codes have Medi-Cal policy and/or frequency restrictions as noted:

- Code L4002 is limited to 16 per year.
- Codes L1932, L2005 and L5856 – L5857 are limited to one in three years.
- Codes L2232, L5685, L6694 – L6698 and L7181 are limited to two in three years.
- Codes L2005, L2232, L6694 – L6698 and L7181 require prior authorization.
- Codes L1932, L2232, L4002 and L5685 are reimbursable to podiatrists.

Reimbursement Adjustments for Orthotic Procedures

The maximum reimbursement rates for orthotic HCPCS codes K0646 and K0648 have been revised.

HIPAA Code Conversion for Respiratory Care Practitioners

Effective November 1, 2005, billing codes for respiratory care practitioners will be revised in compliance with HIPAA. The following interim HCPCS codes will be terminated:

- X4700 (respiratory care evaluation)
- X4702 (respiratory care case conference)

Respiratory care practitioners must now bill for their services with the following Evaluation and Management CPT-4 codes:

- 99202 (office visit, new patient, level 2)
- 99212 (office visit, established patient, level 2)

Code 99202 may be billed by a respiratory care practitioner once every three years, however, the recipient must not have been seen for any reason during the preceding three-year period by the same respiratory care practitioner.

Code 99212 may be billed by a respiratory care practitioner once in six months by the same provider, for the same recipient, with prior authorization.

Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update*.

Labor Charges for Replacement of DME, Supplies and Accessories

HCPCS code E1340 (repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes) is not reimbursable for the replacement of specified:

- Stand-alone items.
- Separately reimbursable accessories or supplies that are rented or purchased to support patient-owned equipment.

Stand-Alone Items
The following procedure codes identify stand-alone DME items:

A4660, A4670, E0100, E0105, E0110, E0112, E0114, E0117, E0188, E0189, E0199, E0210, E0241 – E0246, E0484, E0602, E0710, E0780, E0942, E0944, E0945, S8185, S8265

Separately Reimbursable Accessories or Supplies (Rented or Purchased)
The following procedure codes identify accessories or supplies that are separately reimbursable with the rental or purchase of their associated equipment:

A4230 – A4232, A6550, A6551, E0352, E2360 – E2365, K0601 – K0605

Retroactive to dates of service on or after November 1, 2004, claims for the replacement of the HCPCS codes listed above will not require a statement that the item replaced is for patient-owned equipment in the *Reserved For Local Use* field (Box 19). EDS will automatically reprocess claims for codes previously denied for lack of this statement.

This information is reflected on manual replacement page dura 10 (Part 2).

Intermittent Catheters with Attached Collection Bags Reimbursement Change

Effective for dates of service on or after December 1, 2005, billing code 9943N (Intermittent catheters with attached collection bags) that is not included under a manufacturer contract agreement will no longer be a Medi-Cal benefit.

There will be a 60-day transition period between October 1, 2005 and November 30, 2005, when providers will be allowed to bill for both the non-contracted products and the newly contracted products. This will allow providers to dispense existing stock as needed and allow providers to begin purchasing and dispensing the new inventory of contracted products.

This information is reflected on manual replacement pages mc sup lst4 7 thru 21 (Part 2).

Updated Secondary Diagnosis Codes for Incontinence Supply Products

Effective October 1, 2005, the following new and updated ICD-9 codes will be accepted as the secondary diagnosis for incontinence supply products:

ICD-9 Code	Description
788.30	Urinary incontinence, unspecified
788.31	Urge incontinence
788.32	Stress incontinence, male
788.33	Mixed incontinence (male) (female)
788.34	Incontinence without sensory awareness
788.35	Post-void dribbling
788.36	Nocturnal enuresis
788.37	Continuous leakage
788.39	Other urinary incontinence

Please see **Diagnosis Codes**, *page 5*

Diagnosis Codes *(continued)*

Also, ICD-9 code 300.11 (conversion disorder) is removed from the list of acceptable secondary diagnosis codes.

Note: The following codes continue to be accepted as the secondary diagnosis for incontinence supply products:

ICD-9 Code	Description
307.6	Enuresis (non-organic)
307.7	Encopresis (non-organic)
787.6	Incontinence of feces
788.3	Incontinence of urine

The updated information is reflected on manual replacement page hcfa comp 13 (Part 2).

CPT-4 Procedure Codes and Modifiers Billing Reminder

Providers are reminded that they must select the appropriate CPT-4 code and modifier when billing. The CPT-4 code descriptor must match the procedure performed.

This information is reflected on manual replacement page hcfa comp 16 (Part 2).

FFS/MCN Information Removed from Manual

Fee-for-Service/Managed Care Network (FFS/MCN) pilot program information is being removed from the provider manual. FFS/MCN was terminated effective for dates of service on or after July 1, 2003. Information about the program, which consisted of Placer County Managed Care Network (Health Care Plan [HCP] 640) and Sonoma County Partners for Health Managed Care Network (HCP 642), was retained in the provider manual for a period of two years to help providers with final billing.

Providers should remove pages mcp ffs bil 1 thru 5 (Part 2) from their manuals.

Inpatient Provider Cut-off Date for Proprietary and Non-HIPAA Standard Electronic Claims Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal has established a plan to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claims transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005**, proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cut-off dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for Durable Medical Equipment and Medical Supplies iii/iv* *****
Remove and replace:	cal child bil 1/2 * dura 9/10 hcfa comp 13/14 and 15/16
Remove: Insert:	mc sup lst4 7 thru 12 mc sup lst4 7 thru 26 *(new)*
Remove:	mcp ffs bil 1 thru 5
Remove and replace:	modif app 3/4 *

* Pages updated due to ongoing provider manual revisions.